THE REPORT OF THE ADVISORY COMMITTEE ON DENTAL CARE FOR SENIORS IN NEED

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April 10, 1989

The Honourable Elinor Caplan,
Minister Of Health,
10th Floor, Hepburn Block,
Queen's Park,
TORONTO, Ontario
M7A 2C4

Dear Mrs. Caplan:

I am pleased to present to you the Report of the Advisory Committee on Dental Care for Seniors in Need.

During the ten months of study, the diversity of backgrounds and interests of the Committee members was helpful in exploring the many areas necessary to adequately address the terms of reference and to arrive at a consensus report and recommendations.

In addition to presenting particular recommendations dealing with the institutionalized and homebound elderly, we have also suggested criteria that we recommend be used in the development of any future program for independently-living seniors.

We hope that our efforts will result in programs that will improve the dental health status of Ontario seniors.

Sincerely,

T. W. Hicks

Dr. T. W. Hicks, D.D.S., D.D.P.H.
Chairman,
Advisory Committee On
Dental Care for Seniors in Need.

TWH/nr

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REPORT OF THE ADVISORY COMMITTEE ON DENTAL CARE FOR SENIORS IN NEED

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*Appendices available for use in the Ministry of Health Library, 15 Overlea Blvd, Toronto, M4H 1A9.

GLOSSARY OF TERMS
(in the context of a dental plan for seniors)

Accessible: eligible seniors must be able to benefit from required services by removing financial, physical and other barriers to care.

Benefit Limits: limitations which may be imposed upon services. These could include an annual maximum limit to fees charged, a limit upon frequency of particular services, etc.

Case Review: the monitoring and coordination of treatment rendered to patients with specific diagnoses or requiring high cost or extensive services.

Co-insurance: the plan pays a fixed percentage of the fee with the balance paid by the patient.

Comprehensive: a seniors' dental plan should offer a range of services in order to properly treat existing disease, maintain dental health and prevent future occurence.

CLC (Collective Living Centres):
- (i) Nursing Homes
- (ii) Chronic Care Hospitals
- (iii) Chronic Care Wards of Acute Care Hospitals
- (iv) Homes for the Aged
- (v) Rest and Retirement Homes

Deductibles: usually a flat fee imposed upon the patient for each service, office visit or treatment series.

Dentate: with natural teeth

Direct Reimbursement: payment is made directly to the practitioner by the patient who then submits the bill to the funding agency for reimbursement. It is a payment mechanism with no claim forms or claims adjudication procedures although it will include a pre-set annual maximum dollar benefit.

Edentulous: without natural teeth

FBA — long-term provincial welfare assistance program administered under the Family Benefits Act. (The usual recipients are sole support parents and the disabled).

GAINS: — Guaranteed Annual Income Supplement (provincial assistance)

GIS: — Guaranteed Income Supplement (federal assistance)

OAS: — Old Age Security (federal assistance)

Portability: — the ability to move earned benefits from plan to plan without loss.

Universality: — open eligibility for seniors to all services offered by a plan without limit or exception

EXECUTIVE SUMMARY

Although information about the dental health status of Ontario seniors is limited, it is clear that many seniors have high levels of unmet dental needs. In addition, a growing number of seniors are retaining their natural teeth and have higher expectations for a lifetime of good dental health.

Many cannot afford dental care and those residing in institutions, and some who are homebound, may have difficulty in accessing services. In addition, there are a variety of attitudinal, behavioural, ethnic, social and other barriers underlying the relatively poor dental health of many seniors. At present, organized dental services for seniors in Ontario only affect a small percentage of this population.

The Advisory Committee, recognizing the important contribution of seniors to our society and the relationship of good dental health to overall well-being and feelings of self worth, recommends a dual approach to the provision of dental preventive and treatment services to seniors.

Firstly, specific recommendations support programs in the area of health promotion and prevention for all seniors delivered by local health units in conjunction with the Ministry of Health and local community groups.

Secondly, the Committee recommends a dental treatment program for seniors, targeted to those in dental and financial need and phased in according to available resources. The administration of dental treatment services to residents of collective living centres (CLCs) and the homebound elderly is delegated to local health units. A number of options are discussed with respect to a dental program for seniors living independently in the community. The Committee has developed a list of criteria to be used in the development and assessment of the alternatives to meet the needs of these seniors.

The Committee also developed a list of covered clinical treatment services, some of which would require prior approval. Reasonably sound cost estimates have been projected for dental services for the institutionalized seniors. Less reliable projections are included for those living independently due to the paucity of current programs and data.

General recommendations are included for increased educational opportunities for caregivers, increased support for research and the provision of regulations to ensure proper daily oral hygiene care in institutions.

RECOMMENDATIONS

The Advisory Committee on Dental Care for Seniors in Need recommends:

1. THAT a dental care program, funded by the Ministry of Health, be introduced for seniors resident in the province of Ontario, to include health promotion, and preventive and restorative (curative) clinical services.

2. THAT a dental health promotion program for all seniors be provided through local health units, under the Health Protection and Promotion Act (Mandatory Health Programs and Services).

3. THAT a dental preventive program be made available for residents of Collective Living Centres and the homebound elderly, and that the following services be included in the Healthy Elderly section of the mandatory programs under the Health Protection and Promotion Act to include:

   (1) Dental Screening of residents.

   (2) Referral of those in need of restorative services.

   (3) Provision of preventive measures.

   (4) Annual in-service presentations to caregivers.

4. THAT the dental treatment program for Collective Living Centre residents and the homebound elderly be managed by local health units.

5. THAT the options for design, funding and administration of a dental program for seniors residing outside of Collective Living Centres should be assessed using the criteria set out in this report.

6. THAT the dental program for seniors cover specific clinical services which can be provided without prior authorization and further services which can be provided following authorization by an appropriate agency, as listed in Appendix E.*

7. THAT, according to available fiscal and human resources and manpower, dental treatment be provided in the following order of priority -

   (i) GAINS A recipients
   (ii) GIS recipients
   (iii) Seniors with incomes equivalent to GIS plus 15%
   (iv) All seniors registered with OHIP.

*Appendices available for use in the Ministry of Health Library, 15 Overlea Boulevard, Toronto, M4H 1A9.

8. THAT the Ministry of Health and the Ministry of Community and Social Sevices introduce regulations ensuring an appropriate level of daily mouth care for all senior residents of CLCs in their jurisdiction.

9. THAT geriatric and gerontological educational opportunities for dental health care providers be enhanced.

10. THAT the Ministry of Health strengthen support for research in geriatric dental care.

DENTAL HEALTH EXPECTATIONS OF SENIORS

It is when we cannot manage to chew a good variety of foods that we come to realize just how much a healthy mouth contributes to the quality of our lives. When we lack teeth, or when our own teeth are uncomfortable much is taken away from one of life's simple pleasures.

And if we are snaggle-toothed or have faces collapsed from lack of tooth support, it is not long before we are forced to admit that social acceptability - even our sense of our own self-worth - is influenced by our appearance.

To most young adults it is common knowledge that teeth can be preserved and restored. In the Ontario of to-day most people of working age expect to keep their own teeth for life - and they expect these teeth to be both comfortable and attractive.

This Committee senses, though, that the high and not unreasonable expectations of the young are not nearly so common among those who have retired. We see, all too frequently, a resigned acceptance that dental deterioration is inevitable. And we see this same attitude of hopelessness in many of the people whose responsibility it is to help our elderly when they become less independent that they once were.

We have become convinced that negativism has lead to neglect and that deterioration has thus been allowed to take place. Much unnecessary hardship results. But we know that preventive dental care is effective and prevention is as applicable to the old as to the young. And it is true for everyone that careful restoration of tooth structure and - when teeth have been lost - firmly attached prosthetic replacements, contribute much to one's comfort and confidence whatever one's age.

The dental needs of the elderly of Ontario are best understood, we believe, when one begins by acknowledging this fundamental conflict and contradiction between what we take to be good care for younger adults, and the too common minimal care and treatment that is seen - even by many of the elderly themselves - as all that is needed for old people. A retired person has as much need for self care, or to be cared for, as does anyone else. Seniors have at least as much need to plan for their futures, to intercept small problems, and to do things now so that in the future they will not have to ask the impossible.

I INTRODUCTION

The Committee

In 1988, the Honourable Elinor Caplan, Minister of Health, established an Advisory Committee on Dental Care for Seniors in Need and provided the following terms of reference which have formed a framework for the development of this report:

1. To review and assess available information on the dental status of Ontario residents aged 65 and older, and assess the availability, accessibility and adequacy of current programs in meeting these needs.

2. To set goals for the restoration and maintenance of dental health for this age group, and identify priority target groups where assistance is most needed and most effective.

3. To define essential basic dental care (preventive and curative) services and present options for possible delivery mechanisms that could be used to provide services to the target group identified.

The Committee membership (Appendix "A")* was aware of the need to put personal and professional interests aside in order to develop a proposal which would best serve Ontario's seniors.

The Committee, as a rule, met every two weeks from April 1988 to February 1989. It received and reviewed numerous scientific studies and articles (Appendix "B"),* and submissions from agencies, interest groups and individuals. The submissions are summarized in Appendix "C".*

Members, especially the chairman, discussed various issues with the public and provided general information about the Committee's work. Consultations were also arranged with the Ministry's Nursing Homes Branch with regard to oral care standards in Nursing Homes. A visit to the Queen Elizabeth Hospital was scheduled in order to obtain first-hand information about one arrangement for providing oral care and dental treatment to institutionalized seniors.

Overview

In Ontario, there are more than one million residents over the age of 65. Seniors are increasing both in absolute numbers and as a percentage of the population. The dental health experiences of the young elderly are different from those of the older

*Appendices available for use in the Ministry of Health Library, 15 Overlea Boulevard, Toronto, M4H 1A9.

elderly. The former have been exposed to a modern dental care system which has not only preserved more of their natural dentition, but has also provided them with enhanced expectations about their future dental health.

From evidence presented and discussions held by the Committee we believe that:

- oral health can and should be maintained throughout the full life span;

- poor oral health, especially if neglected, can affect general well-being and lead to serious health problems. These secondary effects are particularly threatening for seniors whose health may already be compromised by other conditions;

- good oral health also contributes to quality of life issues such as pleasurable eating, personal appearance and a sense of self worth;

- both seniors and those responsible for their care should maintain the same high expectation of oral health status in later adulthood as is associated with those of younger ages.

II DENTAL HEALTH STATUS AND NEED FOR SERVICE

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II DENTAL HEALTH STATUS AND NEED FOR SERVICE

A. Ontario Seniors

From a review of existing data on the dental health status of Ontario seniors, which was based in large part on a previous review commissioned by the Ontario Society of Public Health Dentists, the Committee can state with some confidence that:

- an increasing proportion of seniors are retaining their natural teeth;
- seniors with natural teeth (dentate) have greater need for dental health promotion, prevention and treatment services than those who have no natural teeth (edentulous);
- residents of Ontario collective living centres (CLCs) are older compared to seniors living in the larger community, and a higher proportion of CLC residents are edentulous;
- dentate residents of Ontario CLCs have high levels of unmet treatment needs consistent with their low rates of visiting for dental care;
- dentate seniors living independently in the community also have high levels of unmet needs in spite of self-reported high levels of dental visitation within the past year.

These studies do not provide sufficient information on the following areas and hence the Committee can only state it believes that:

- dental health is increasingly valued by younger cohorts of seniors and they will demand dental health treatment services to enable them to retain their natural teeth over their life span. These expectations have been generated mainly through preventive and health promotion efforts of the dental profession, health units, the Ministry of Health and others;
- the present overall relatively low level of need for seniors living in CLCs (the result of high edentulism) will likely increase as new cohorts with greater proportions of dentate seniors move into CLCs;

- the cost of dental care is a burden to many seniors and entirely outstrips the resources available to most individuals who have been retired for some years and have no private pension, or a non-indexed private pension;

- It is clear that many seniors, regardless of their residence, i.e., independent living of institutionalized, have unmet needs and that available services are insufficient.

A more detailed description of the dental health status of seniors is appended (Appendix "D").* There is a paucity of data relevant to the dental health status and needs of Ontario's current and future seniors. Particularly for the independently living seniors, there are no representative province-wide data upon which one could with a degree of confidence, summarize status. Secondly, few seniors are covered by private dental plans, and information on those that are covered was not made available to this Committee.

Recently the National Health Research and Development Program of the federal government has approved a research project in Ontario - "Oral Health and Treatment Needs Among Ontario's Current and Future Elderly". The project will interview and examine seniors from the City of Toronto, the City of North York, Simcoe County and the Districts of Sudbury and Algoma and analyze their treatment histories. The representative nature of the sample will provide data which can be generalized for future provincial planning purposes.

The base-line phase will begin early in 1989 and the follow-up examinations are planned for 1993. This kind of research has potential for providing information on disease incidence and accurate treatment needs of Ontario's current and future seniors.

B. Other Jurisdictions

It would have been helpful to the Committee and to future health planners, to compare the dental health status and treatment needs of Ontario's seniors to seniors in other jurisdictions. Unfortunately, with a few exceptions, general comparisons cannot be made with any degree of confidence. The data which are available suggest that the dental health of seniors in Ontario is equivalent to seniors in Vancouver, Winnipeg and the USA. In Quebec it appears that there is a higher percentage of seniors who are edentulous. There is evidence to suggest that, although the level of dental caries is similar to other areas, Ontario seniors receive less treatment than residents of Alberta or the USA.

*Appendices available for use in the Ministry of Health Library, 15 Overlea Boulevard, Toronto, M4H 1A9.

III CURRENT DENTAL TREATMENT PROGRAMS

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2. Seniors Resident in Collective Living Centres

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III CURRENT DENTAL TREATMENT PROGRAMS

A. Government Sponsored Programs

1. Seniors Living Independently

a. Federal Programs

The Veterans Affairs Canada dental program was implemented in 1944 for all veterans receiving a war pension who have no other pension or income. The program provides two levels of coverage: (a) Comprehensive coverage is available to veterans with some war-related damage but not necessarily suffered in a war theatre; and (b) a program for veterans who actually served in a war which provides virtually all services required. Although seldom necessary, the services are available on an at-home basis. Portable equipment is available in Ottawa and Toronto for use in providing services in patients' homes. Seventy-five percent of services are provided by private dentists and the balance through the sixteen Department of Veterans Affairs dental clinics located throughout Canada. The Department of Veterans Affairs reimburses providers 90% of the current provincial fee schedule (except for British Columbia and Manitoba where the reimbursement level is 100%). Data are not available to project a per capita cost for the program. In 1982/1983 only 37% of eligible veterans utilized the plan.

Native People who are "Status Indians" in Ontario and live on a reservation are eligible to receive dental care provided through various means which are operated by the Medical Services Branch of Health and Welfare Canada. Should "Status Indians" leave the reserve, dental care will be provided for one year.

b. Provincial Programs

(1) Ontario

Through the Ministry of Community and Social Services, aged recipients who do not qualify for OAS and are permanently unemployable or disabled, receive basic dental care. Sole support parents in receipt of FBA are eligible for emergency dental care

and their dependent children receive basic dental care services. It is estimated that some 5,000 seniors are eligible to receive care under these programs.

(2) Comparison with Other Provinces

In Canada there are two active major provincial dental programs directed toward seniors and one program which has suspended coverage. Generally, they do not contain specific health promotion components so it is not surprising that the utilization rates vary between 16% to 37%.

(a) The Alberta Extended Health Benefits Dental Program was implemented in 1973 and originally covered senior citizens age 65 and over, their spouses and dependents. Subsequently, in 1983, coverage was extended to low income widows and widowers age 55 to 64 and their dependents.

The early utilization rates of 25% to 27% were elevated to 37% following a promotional program conducted in 1981. The 1986/1987 rate was 38% with a total eligible population of 236,040.

The program provides basic dental services including diagnostic, restorative, periodontic, prosthetic, oral surgery and denture therapy. Orthodontic services can be covered through prior authorization. The treatment is done by private practitioners at their offices. Dentists may provide partial and complete dentures. Dental mechanics may provide complete dentures and repairs to dentures.

The plan is 100% funded by the Alberta government reimbursing at 75% of the Alberta Dental Association Fee Guide. Extra billing is permitted and 75% of dentists billed the plan directly. The per capita cost to the plan for all eligible seniors was $86.36 in 1982/1983. This has risen to $115.18 in 1986/1987 with an average planned cost per user of $305.00. The amount of extra-billing charges is not known.

(b) The Yukon Territory Dental Care Program (Extended Health Care Benefits) was implemented in 1982 and covered 1,273 low income seniors over the age of 65 with a Pharmacare Card. It covers registered residents 65 years of age and over, and their spouses 60 years of age and over. The cost of dental care including dental restoration, dentures and preventive services is provided subject to frequency and financial limitations. Payments on behalf of any one eligible beneficiary shall not exceed $1,200 for any consecutive two-year period.

Services are provided by private dentists working in their offices. The EHCB is 100% funded by the government and in 1983/1984 the per capita cost per eligible seniors was $47.00 which was covered by an annual budget of $60,000.

(c) A Dental Care Plan of British Columbia was implemented in January 1981 and terminated in September 1982. Seniors age 65 and over receiving premium assistance through the Medical Services Plan were included.

Basic services including dentures were covered by the plan up to an annual maximum of $700.00. Treatment was provided in private dentists' and dental mechanics' offices. Eligible seniors were issued an identification card and the providers billed the plan directly.

The cost for the time period April 1981 to March 1982 is reported to have been $82,732,880 which suggests an annual per capita cost of roughly $505.00.

(d) Other Programs

There are a variety of seniors' dental care programs in other provinces receiving governmental support. The majority of seniors receiving such assistance would be institutionalized or indigent. Most provinces have arrangements similar to Ontario when local social service departments, operating under permissive legislation, may assist seniors not eligible for regular income assistance programs.

c. Local Government Programs

Recipients of General Welfare Assistance in Ontario may be provided with dental care services through special assistance and supplementary aid as legislated through the General Welfare Assistance Act. This portion of the legislation is permissive and the services provided vary by municipality.

There are a few other programs in the Province which are funded by local governments and managed by health units which offer dental services to seniors living independently in the community. They include:

City of Etobicoke Health Department: Under this program all "leisure citizens" (60 years and over) are eligible for screening and preventive services. If treatment is needed, they may receive comprehensive services at no charge, except lab costs which are paid by the senior. Approximately 1,000 patients per year are seen.

Ottawa-Carleton Health Unit: This health unit has an agreement with the local Social Services Department, whereby patients eligible for social support receive dental services in the Health Unit clinics with Social Services reimbursing the Health Unit. Services are comprehensive and between 200-300 patients are seen annually.

City of Toronto Health Department: In 1989 and 1990, the Department will open four community clinics for low income seniors (income below G.I.S. + 10%). Services will be comprehensive and free. Approximately 9,000 seniors per year will be seen.

City of York Health Department. This Health Department offers a program for marginal income seniors. Comprehensive services are offered at no charge except lab costs, which are paid by the patient. Approximately 300 patients per year are seen.

2. Seniors Resident in Collective Living Centres

a. Federal Programs

Veteran Affairs Canada programs -
(see Sec. III. A. 1. a., page 5).

b. Provincial Programs

(1) Ministry of Health

All residents of psychiatric hospitals including those over the age of 65 receive full dental services including dentures. The service is provided by a dentist on staff at no charge to the patient. A sessional dentist on a fee for service basis may also be available.

All residents in Homes for Special Care also receive full dental services including dentures. Services are provided by a local dentist with no charge to patients.

Some chronic care hospitals have dental programs, paid out of the hospital budget. They try to recover the cost of treatment from the patients, if possible.

The Ministry of Health also funds a program of Dental Coaches that travel in northern areas of the province. Emergency service is available to seniors, but the program mainly treats children at no charge.

(2) Ministry of Community and Social Services

MCSS provides a subsidy to Homes for the Aged from which some facilities arrange for dental services for their residents. In the majority of these few facilities, residents leave the home to receive services at a dental office. If they are not physically able to visit a dentist's office, a dentist may come to the home to provide dental care. Some homes will pay for dental services if the resident cannot afford to, otherwise the resident pays for his/her own dental care. If a home does pay for the dental care of a resident the amount can be cost-shared with MCSS. Residents of domiciliary hostels funded by MCSS may be eligible for dental coverage through General Welfare Assistance on an emergency basis.

c. Local Government Programs

Preventive Dental Services:

Most organized preventive and health promotion programs are offered through local health units. Over the past few years, a number of health units began to provide services to some CLCs, incorporating some of the requirements described in the proposed geriatric program under the Health Protection and Promotion Act (Mandatory Health Programs and Services). These activities include biannual screening and referral of residents for treatment, oral hygiene preventive education to residents, cleaning and identification of dentures and in-service presentations to CLC staff.

The level of activity varies across the province. Some units have been able to incorporate most of the program, but more frequently, dental divisions in health units have initiated some features of the service; some might offer the in-service component only, some may only provide the screening service, etc. In many health units there is no specific organized service dedicated to the dental health of seniors.

Recently, the Public Health Branch of the Ministry of Health has completed a review of all mandatory public health programs and services to be offered throughout Ontario by local health units. During the review, the question of mandatory geriatric dental services was deferred pending the recommendations of this Committee.

B. Private Insurance

There is little information which is readily available on the continuation of employee dental benefits to retirees. The major source of information appears to be the Ontario Ministry of Labour whose Research and Analysis Unit is responsible for monitoring all union negotiated contracts in the province. These data represent approximately 30% of the labour force in Ontario who are members of unions.

Discussions with Ministry of Labour staff indicate the following:

- There are approximately 85,000 retired employees in the province who receive dental benefits from former employers;
- They have no record of how many spouses of this number might be covered;
- The number of agreements which include the provision of dental benefits to retirees is showing a slow but steady increase. This is presumed to be in part due to increased awareness on the part of members in the area of dental health and in part to unions generally trying to improve benefits for their members;
- It was felt that it was common practice for employers to extend the benefits offered to bargaining unit employees to management and excluded employees;
- The Ministry of Labour does not keep statistics on employees outside of negotiated contracts and it was clear that such information is not easily obtainable;
- Benefits can be lost if the former employer goes bankrupt;
- There are some sectors of the economy where people are not covered by insurance during their working years or in retirement (agriculture, service industries, etc.);

A review of several union contracts was completed in order to determine the scope of dental benefits offered to retirees. Dental plans, however, do not form part of the negotiated contract and are only referenced within the contract. The following points were noted in the review:

- Some plans cover early retirees only and coverage ceases at age 65;
- In some plans, the employer is responsible for the full premium, while in others, the retired employee must pay a portion of the premium;
- Some plans cover the retiree only, some cover spouses;

- Some plans have a limit on the amount which is covered;

- Some plans allow for coverage for the spouse for a period of time after the death of the retiree.

From the review, it is not possible to outline any particular plan for retirees covered by union contracts. As well, we cannot determine how much use a retiree might make of dental benefits once association with the employer ceases. It is estimated that only 10-15% of retirees are eligible for dental benefits and this is not expected to increase significantly. In addition, the range of benefits is uneven and there may be no coverage for survivors.

C. Other

Voluntary Dental Treatment Services

There are voluntary organizations such as service clubs, dental societies, etc. providing health related services to seniors. Consequently, they would be involved to varying degrees with the provision of dental health care. It would be difficult to catalogue the contribution made by these organizations. In that they affect a small fraction of Ontario's seniors, each in its own fashion, the Committee wishes to recognize and encourage these efforts without making an attempt to measure their impact upon the general well-being of all seniors.

For example, in 1987, The Toronto Academy of Dentistry, which represents more than 2,000 dentists, purchased portable dental equipment to service residents of Toronto collective living centres. The equipment is placed in CLCs by the Academy on request from administrators. Patients are screened by volunteering dentists and written treatment plans are drawn up. Administrators attempt to arrange payment for necessary services from the patient's family and when approved, dentists return to the CLC's to provide treatment.

In calendar year 1988, the Academy program treated 326 patients in three CLCs, two nursing homes and one home for special care (HSC). The patients in the nursing homes had an average age of 73 and two-thirds of them were female. Not all residents in the HSC were seniors. Two-thirds of all services were extractions or repairs/adjustment to prostheses and one-third were preventive/restorative procedures.

The Academy reports that it was difficult to arrange for payment for services in the extended care setting whereas the trustees of handicapped patients approved care for all patients requiring it in the HSC. Fifty per cent of patients screened in nursing homes subsequently received treatment whereas 75% of HSC residents did so.

Early in 1988, the Ontario Society of Public Health Dentists surveyed their membership asking them to report on the status of organized dental treatment services for seniors in their areas. Some activities may have been overlooked, but it can be stated that organized screening and treatment delivery programs are available to a small percentage of CLC residents.

Approximately fifteen communities or areas reported some activity directed toward dental care for the elderly with no consistent delivery model described. Briefly,

- some programs were organized through a CLC, some by a local dental society, some by public health units and some by individual dentists.

- usually the resident was expected to bear the total cost of necessary treatment. Occasionally the institution took some responsibility for a portion of the costs, in some the service was offered at "no charge" to individuals without third party coverage and in others the service was provided without charge through a free clinic operated by the health unit.

- estimates of the number of seniors affected are based on approximations only. The report suggested that perhaps about 5,540 seniors received dental treatment at the local level. Some of these would have been funded by MCSS (see Sec. III, 2, B(2), page 10).

IV GOAL AND PRINCIPLES FOR A DENTAL PROGRAM IN NEED

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IV GOAL AND PRINCIPLES FOR A DENTAL PROGRAM FOR SENIORS IN NEED

The goal of any dental program for Ontario seniors should be to enable seniors to have a functioning, comfortable, relatively disease-free mouth, thus contributing to overall quality of life.

Any such program should include the following principles:

A. **Comprehensiveness.** It should provide appropriate health promotion and education, preventive and curative services based on individual needs;

B. **Accessibility.** It should remove financial and mobility barriers to obtaining care;

C. **Sensibility and Sensitivity.** It should acknowledge the individual's other health and life circumstances and right to informed choice of care to be received.

A. Comprehensiveness

1. Health Promotion For All Seniors

In the past decade the health field has seen a shift in emphasis from curative and treatment to prevention and promotion. Most recent examples are the World Health Organization Ottawa Charter on Health Promotion; Achieving Health for All, Health and Welfare Canada; and Health for all Ontario, 1987 Report of the Panel on Health Goals for Ontario.

This Committee feels strongly that any dental plan for seniors must include dental health promotion as a major component. The following components of health promotion are presented to clarify important features which should be included in any health promotion plan.

Community development is the "process by which a community decides collectively on its needs and develops strategies to utilize its collective power to meet their needs" (OCDA, 1986). The term community refers to a specific group of people, defined by geography and/or affinity (e.g., age). Thus, under a dental program, the seniors of Ontario are the community. The needs defined are related to dental health and the strategies to be developed will involve seniors at the local level. The ongoing role of the Toronto Mayor's Committee On Aging in developing a Dental Health Promotion campaign for seniors in the City of Toronto is an example of this.

Health education is the means whereby members of a community acquire specific new knowledge, develop new attitudes and adopt specific new behaviours. Under a dental program, the primary communities include independently living seniors, seniors in collective living centres, care-givers and the various dental professional groups. The dental education materials developed for seniors by the Canadian Dental Hygienist Association and by the Canadian Dental Association are examples of this component.

Legislation and policy refer to the development of specific laws and policies by government to enhance the overall health of the community. Fluoridation of water by municipalities is a classic example of this component.

Advocacy refers to the speaking out for the correction of inequities or injustice. In a dental health context it could mean organized seniors groups calling for dental curricula that reflect the aging population.

Finally, an increased **awareness** means essentially the placing of an issue on the agenda of an individual, a group or a community. In a seniors' dental health plan seniors, professionals and families would be targeted.

A complete health promotion program for seniors would include all of these components. For example, community development might consist of health promotion proposals emanating from seniors' groups and other local interest agencies. Included in these proposals would be recommendations to increase the community's knowledge of the dental health needs of seniors, to change attitudes about seniors' dental health and encourage new behaviours by the seniors themselves, i.e., improving their individual oral health care habits and taking advantage of services which become available. As a result of community action it may become clear that a specific ethnic or language group in the community needs special assistance in the delivery of dental care and the health promotion program could addess these issues.

2. Preventive and Restorative (Curative) Clinical Services

The Committee prepared a Suggested List of Covered Clinical Services that in its opinion would cover those procedures most necessary for the elimination of pain and infection, maintenance or restoration of health, comfort and function. (see Appendix "E")*

*Appendices available for use in the Ministry of Health Library, 15 Overlea Boulevard, Toronto, M4H 1A9.

The Committee has prepared a list of procedures under Part I that encompass services required to keep a mouth healthy. These are routine but they are also essential because they prevent or relieve pain and keep patients from losing teeth or being made uncomfortable. Part I services prevent or limit further deterioration consistent with generally accepted practice, and are services that normally do not need extensive planning and analysis, and therefore they should not be delayed. Although dentures are not provided under other government programs, it is reasonable that first-time dentures be included in a plan for seniors under Part I for seniors who can benefit from them.

Services in Part II are required less frequently, are more costly, and, as such, should, in the Committee's opinion, be subject to some form of "pre-authorization" or prior approval, in the form of case review, by an authorizing agency operating under standardized guidelines for adjudication developed through dialogue with the dental profession. The Committee has included replacement dentures, fixed bridges, some specialist services and those "unclassified treatment and special services" that are sometimes essential but difficult to list.

The Committee strongly supports the inclusion of the services found in Part II. Especially for seniors, it is important to anticipate what will be the best and most durable dental treatment in the long run. This treatment should be done early when it is not particularly arduous to the senior. Genuine dental needs of seniors vary widely and both present needs and those that can be anticipated in the future are important. Some seniors need little treatment beyond ongoing maintenance, others may need relatively routine procedures and still others have dentitions that require major rebuilding which can be time-consuming, painstaking and expensive. Nonetheless, if the goal of a dental plan for seniors is to provide "functioning, comfortable, relatively disease-free mouths", services under Part II must be available for those who require them.

Given the complexity and the greater difference in needs of this age group, the Committee appreciates the need for an effective process of consultation and adjudication. In order to accomplish this goal, requests for prior authorization through case review must be submitted to an authorizing agency.

This request, for example, would be reviewed by a local committee composed of representatives of the authorizing agency, local dental and denture therapist societies, and a local seniors' group. The activities of this committee would be coordinated by the representative of the authorizing agency. This committee should meet frequently enough to

minimize delays in the approval process and recognize a responsibility for the well-being of the seniors in addition to concerns about cost containment and claims adjudication.

B. Accessibility

1. Targetting vs Universality

Ontario's seniors have helped to develop our society to among the most favoured in the world, yet they continue to bear an excessive burden of poor dental health compared to those of us who are reaping the rewards of their efforts. They have lived through the era when the knowledge to prevent dental disease was rudimentary, dental disease was rampant and treatment services were limited both in technology and availability.

The Committee reviewed the literature about universality and accessibility* and accepts the precepts presented by these documents. It further endorses the view that dental health services are an integral part of health care. In addition we have seen evidence that policies, such as significantly large user charges, deductibles and co-insurance, have the effect of limiting accessibility. These deter the poor and the elderly, the very people for whom the benefits of this program are most needed. Similarly, policies which impose minor charges which are insignificant to clients, cost more to collect and administer than they raise in revenue.

It is apparent, that health care costs are presently consuming about a third of Ontario's tax resources and any new burden upon these resources should reflect some measure of constraint. Furthermore, it is appreciated that a small percentage of seniors do have some level of private post-retirement dental insurance benefits and others are economically capable of paying for their own dental care.

For these reasons, and provided that the principles enumerated on page 22 of this report are applied, the Committee accepts that there may be a need for a phased-in, targetted approach to the provision of dental services to Ontario's seniors.

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*a. Report of the Royal Commission on Health Services 1964.
b. The Health Services Review (Hall II) 1980.
c. The Report of the Parliamentary Task Force on Federal-Provincial Fiscal Arrangements: Fiscal Federalism in Canada (the Breaugh Report) 1981.
d. User Charges for Health Service: A Report of the Ontario Council of Health. R.F. Badgely and R.D. Smith. 1979.
e. Extending Canadian National Health Insurance: Policy Options for Pharmacare and Denticare: Ontario Economic Council Research Study. R.G. Evans and M.F. Williamson 1978.

2. Mobility and Income

A number of factors influence a senior's decision to seek dental care. There are, however, two factors which are considerably more limiting than others. If an individual is physically unable to gain access to treatment facilities, it is unlikely that he/she will receive any care, and even then, service may only consist of emergency relief. Similarly, if a senior cannot afford to pay for services, it is unlikely that he/she will receive care. Indeed, financial concerns are usually reported by seniors as a major barrier to treatment.

Apart from these two absolutes there are a variety of reasons why seniors, more so than any other group in society, are at an elevated risk for dental disease. Some of these confounding factors could include ethnicity, language, attitudes, past practices, family custom, past dental experience (fear), undue concerns about costs, ignorance of new treatment techniques, feeling that any treatment would be wasted because of their age, etc. Although mobility and income could be seen as the "hard deterrents" in the delivery of dental care for seniors, these "soft deterrents" are also at work. If the goal of a seniors' dental program is a dentally fit, functional and healthy population of seniors, these other factors must be addressed through organized community efforts in health promotion.

3. Target Groups Based on Income and Mobility

Acknowledging that mobility and income are primary factors limiting access to dental care, the Committee agreed that each factor consisted of two variables. A senior either could afford to pay for care (adequate income) or not (low income). Similarly, a senior either could physically access dental care (mobile) or not (immobile).

Using these variables, a program of dental care for seniors must recognize the different requirements of the following four distinct categories of seniors.

	Category	Requirements
1.	Seniors with compromised mobility and low income	Health promotion, subsidized care and assistance in accessing dental care
2.	Mobile seniors with low income	Health promotion and subsidized care

3.	Seniors with compromised mobility and adequate income	Health promotion and assistance in accessing dental care
4.	Mobile seniors with adequate income	Health promotion

C. Sensibility and Sensitivity

The Committee believes that most of the professionals and auxiliaries who will be expected to care for the dental needs of Ontario's elderly are not now entirely ready for the tasks. Dental services will best serve the interests of seniors if they are sensible in nature and sensitive in application by acknowledging the individual's health and life circumstances. The Committee believes that these attributes can be achieved through changing attitudes of providers, education and research.

1. Provider Attitudes

Although many dental care providers readily provide care to younger age groups, this enthusiasm is not as evident with the aged. Many providers, for example, willingly undertake dental treatment for a distraught and unmanageable child, but are reluctant to provide care to other than fully cooperative seniors.

Seniors are burdened with stereotypes in the same way that many other groups become stereotyped. There are misconceptions that the elderly are poor, they are in poor health, that they don't care about their appearance, that they are not willing to change behaviour, etc. These misunderstandings will disappear as providers gain experience with the elderly. Although the elderly may require some considerations different from other age groups, they are, after all, just people in need of care. In that respect, they are not different at all.

It is interesting to reflect that analogous difficulties were encountered some two generations ago when dentistry first began to realize the importance of comprehensive dental care for children.

2. Education

Dental care providers need to be more aware than they presently are of the special dental problems that the elderly encounter. Aging presents a particular set of dental problems and a somewhat different approach to prevention and treatment than is generally true of a younger population. When planning treatment for seniors, experienced practitioners find that more variables must be taken into consideration than with younger patients.

The value of daily oral hygiene care is a good example. Following years of use, episodes of active disease and treatment, the condition of the dentition becomes such that it requires an appropriate level of oral hygiene. Unfortunately, this comes at a time when the elderly may be forgetful and less agile in managing the skills required to complete these daily routines. Relatives and caregivers who assist the elderly when they become dependent may accept the need to provide other health-related services but not think to provide the careful oral hygiene that is needed. For that reason many elderly require monitoring and every opportunity taken to improve the quality of daily care.

Particularly for the senior elderly, extensive dental treatment may not be tolerated and the best decision may be to provide the simplest, the least intrusive and least demanding care. It is important to understand that treatment that has a reasonable expectation of lasting for the rest of the patient's life should not be delayed.

As well, it is necessary for providers to become knowledgeable about demographic trends and how senior's dental needs will change over time as the benefits of better preventive and curative methods become evident.

A comprehensive dental plan for seniors will require practitioners and administrators who are well informed. Thus, the program will require an educational base. Ontario's dental faculties and Community Colleges must be encouraged to develop curricula based on gerontological principles. These institutions must incorporate this essential course content for undergraduates. Continuing education courses should become available for dental personnel already in the field. The Committee recommends a cooperative effort in this regard.

3. Research

The Committee realizes that not enough research has been done into the provision of dental care to the elderly. There are not enough dental health status data upon which to precisely forecast resource needs. There is little scientific information contrasting various program delivery options. There are relatively more data outlining specific treatment modalities, but even many of these articles are not definitive in assessing the benefits of one technique versus another.

Seniors' programs need to be developed intelligently and sensibly based on proven, scientifically-tested methods. A provincial seniors' program will need coordination and must follow standardized recording procedures in order to generate useful data. The program must be able to implement changes that may be dictated by this new information.

In view of this, the Committee recommends that encouragement for research in the area of seniors dental care must come from those organizations and agencies who sponsor research. The provincial government should establish specific funding for geriatric dental research.

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V SERVICE DELIVERY OPTIONS

A. Criteria for Decision-Making

Ontario is a demographically complex province. The Committee recognizing this diversity, realized that there may be a number of service delivery options which could be considered for a dental care program for seniors.

In order to guide the development of alternatives, the following criteria were taken from a number of major, contemporary reports*. The Committee recommends that these criteria be applied in future decision-making affecting the organization of a dental program for Ontario's seniors.

1. **Equity** - a program should provide access to covered services, to those seniors eligible under the plan.

2. **Comprehensiveness** - including measures to:

   (1) reduce the level of preventable dental disease
   (2) eliminate pain and infection
   (3) restore serviceable teeth to functional form
   (4) provide maintenance care for the control of early lesions
   (5) replace missing teeth in order to achieve adequate function and appearance

3. **Quality** - procedures undertaken should be performed at an acceptable technical standard and represent the best choice of treatment for the individual.

4. **Informed choice** - a plan must permit an informed choice of treatment and practitioners.

5. **Accountability** - administrators must be accountable for the consequences of the plan (financial, standard of care, etc.)

6. **Evaluation and monitoring** - the plan must incorporate evaluation and monitoring processes to assure the goals are being met.

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*(a) Health for all Ontario 1987, Report of the Panel on Health Goals for Ontario, Spasoff.

(b) Toward a Shared Direction for Health in Ontario: Report of the Ontario Health Review Panel, Evans 1087.

(c) Principles of Dental Public Health, J.M. Dunning, 4th edition Harvard Press 1986.

(d) The Essential Functions of an Oral Health Care System, World Health Organization Report #750, 1987.

7. **Cost-effectiveness** - a dental plan for seniors should ensure the optimal use of resources within the parameters of points 1, 2 and 3 above.

8. **Preventive/promotional focus** - in spite of the obvious obvious need to offer treatment services, a complete dental service for seniors must include means to prevent dental disease or minimize its effects.

B. Delivery of Health Promotion Services

It is recommended that responsibility for the delivery of health promotion services be delegated to local health units as part of the Ministry of Health's mandatory public health programs under the Health Protection and Promotion Act. Appropriate guidelines would clarify the standards of service to be followed by health unit managers.

The health units were chosen to manage the health promotion services because this role is consistent with their broad mandate under current legislation and such services could be coordinated with other health promotion activities for seniors. The dental division of each health unit, working collegially with other departments, in particular, with the unit's nursing and health education and promotion divisions, would ensure an interdisciplinary approach to overall geriatric programming.

Funding as for other health promotion programs under the Health Protection and Promotion Act is cost-shared. At the outset, the Ministry might consider 100% funding in order to ensure prompt compliance by local boards of health.

The local health unit may choose to provide the entire health promotion service itself or, working with any variety of local agencies (local dental and dental auxiliary societies, seniors groups, other special purpose bodies), delegate the responsibility to others. The responsibility for ensuring that the health promotion service is provided, however, would rest with the local boards of health.

C. Delivery Options for Preventive and Restorative Care for the Mobile Seniors

1. Local Administration

(a) Public Health Units

Each health unit, would be responsible for the administration of the seniors program under the direction of the Dental Director. Eligibility for the program could be administered in a variety of ways.

Option (a)(i): Seniors would visit health unit clinics and receive health promotion and preventive services. They would be seen by appropriate personnel for needs identification. Seniors meeting the Provincial eligibility criteria and found to be "in dental need" would be authorized to seek care from their general practitioner, dental clinic, denture therapist, etc.

Option (a)(ii): There would be no requirement to screen a senior in order to determine dental care need. Any senior meeting Provincial need eligibility requirements could arrange a dental visit to a practitioner or clinic of choice.

The program could be funded through a global budget. Services listed under Part I of the Schedule could be provided to eligible seniors and the claim sent to the health unit if done on a fee for service basis. Alternatively, services could be reimbursed through other payment mechanisms covering all basic Part I services. In either event, some portion of the funds would be designated for services requiring prior authorization.

Requests for services requiring prior authorization would be submitted to the health unit. The request, accompanied by appropriate supporting documentation, would be reviewed by a local committee chaired by the local Dental Director of the Health Unit and at least one representative each nominated through the local dental and denture therapy societies and an appropriate local seniors group. This committee would periodically review submissions from dentists or denture therapists requesting authorization for Part II services.

(b) Local Community Groups/Agencies Option

A variety of local community organizations/agencies could be the administrative agencies across Ontario. The Ministry of Health could request District Health Councils and/or other local planning bodies to identify appropriate organizations/agencies who could develop and manage a dental program for seniors in their area. The Ministry would establish standards and criteria which must be met by the program proposals and may provide incentives to encourage local agencies to develop programs that would provide the most cost-effective services. The local organization/agency could have representation from seniors' groups, professional groups, etc., and this would ensure attention to local needs.

Access to services could be accommodated in a variety of ways. For example, eligibility and need for dental care could be determined by dental staff of the public health unit or at the location (e.g. clinic) where services would be provided. The dentists providing services would submit their claim forms to the administering agency for processing, and prior authorization for special procedures could be handled as described in Section C.1. a. above.

2. Central Administration Option

Once eligibility for benefits is established (as outlined in a and b below), seniors would attend a provider of choice, or a designated provider if required. Once treatment has been rendered, the provider would complete a claim form and submit it to the administering agency. The agency would review the claim to assess validity and determine if the services provided are covered under the terms of the plan. If further documentation is required (e.g., radiographs, etc.), this would be requested from the service provider. Once validity has been established the administering agency would issue a cheque to the provider or claimant, depending on the provisions of the plan.

This type of central administrative mechanism with minimal local involvement in organizing service delivery would be applicable only to the mobile population. Seniors with compromised mobility who need the services to be brought to them would require a separate program, perhaps one operated by public health, the local hospital, etc. In addition, this option would create difficulties in assessing requests for Part II services.

a. Two Tier Model Option

Screening of applicants and verification/authorization of need for care and eligibility criteria would be carried out locally. Local authorization may be delegated to one organizational structure (e.g. boards of health) or a variety of local "agents" as arranged on an area by area basis. Seniors would then obtain care from a practitioner/clinic of their choice, with the practitioner or care organization being reimbursed in accordance with the program guidelines.

b. Private Insurers, Third-Party Administrators, including OHIP Model

Determination of eligibility would be by a special identification card or number issued to the client to present to the provider.

Central administration could be delegated to insurance companies, or to third-party administrators, or to an OHIP model.

D. Dental Care for Seniors with Compromised Mobility (Residents of CLCs and Private Residences)

1. Preventive Program Provided by Health Units (Core Programs)

CLC residents and homebound seniors are particularly vulnerable and at risk for poor dental health due to their decreased mobility. They will not be as affected by health promotion initiatives directed to seniors, in general, nor will they be able to access preventive services as easily as seniors living independently.

In the context of an overall plan, it is important to incorporate a system which recognizes these factors and, in an organized manner, ensures that the dental well-being of seniors in CLCs is not overlooked. To that end, the following minimal activities should be offered by local health units as part of a comprehensive dental program for homebound seniors and those resident in CLCs:

(1) dental screening of residents:

(i) within two months of admission
(ii) all, every two years

(2) Referral to dental care providers for those in need of restorative (curative) services.

(3) Provision of preventive measures, according to individual need, to include:

(i) oral hygiene instruction and plaque control
(ii) cleaning and identification of prosthetic appliances
(iii) application of preventive agents.

(4) Annual in-service presentations to caregivers.

These activities will ensure that seniors in CLCs will be evaluated regularly for dental needs, will be offered an opportunity to receive appropriate restorative (curative) treatment and other preventive services important to the maintenance of a healthy, functional mouth.

The importance of daily oral hygiene care cannot be over emphasized. Without it, dental health will deteriorate in spite of the best treatment and regular clinical preventive services. Supervision of, and assistance with oral hygiene is a nursing care responsibility in CLCs and the responsibility of caregivers attending seniors who are homebound.

It is important that standards of daily oral hygiene care be regulated to ensure that caregiver responsibility, at least in CLCs, is clarified. During regular visits to institutions and home visits, it is recommended that health unit staff monitor the level of oral hygiene care and assist the staff of CLCs to maintain an acceptable standard of mouth care.

2. Options for Delivery of Curative Services

The mobility of many seniors in CLCs is compromised. For some it is a physical problem with a slight difficulty in ambulation. Some are bed-ridden and others are mentally compromised and may be confused or affected by dementia. For these reasons, access to dental care can be an inconvenience or achieved with difficulty.

Since some seniors are physically unable to gain access to dental care at off-site offices, service delivery must be organized in order to meet their dental needs. This would include bed-bound seniors in CLCs and in private residences.

Most patients can be moved but it may be inconvenient and costly, especially if it involves the use of an ambulance. The latter is complicated by the fact that the ambulance is always "on call" for emergencies. The patient may not be picked up on time, in which case the appointment may be lost, or once at the dental office, the patient may be required to wait for a prolonged time before returning to the residence while the ambulance attends an emergency. The availability of adequate transport varies regionally throughout Ontario. This will be more of a problem in rural and remote sections of the province and less in larger urban areas.

There is a concern that if emphasis is placed upon a "transport-out" option, the overall dental health of the residents may be compromised. In view of the cost of transportation and staff co-ordination time, there would be a tendency not to transport if the resident only needed preventive or maintenance care. The staff of the CLC may not recognize the value of these services as compared to more urgent services.

Many residents of institutions or in private homes would require an accompanying relative or care provider, familiar with the management of that particular patient. Medical clearance would be necessary and the CLC patient charts would need to accompany the resident to the dental office.

Family and friends of some CLC residents are willing to assist with transporation. This assistance would represent a cost-saving compared to the expense of arranging some other form of transportation.

It is possible to arrange on-site dental treatment facilities through the use of portable equipment. This equipment is entirely adequate for the delivery of basic dental care - examinations, fillings, extractions, periodontal treatment, denture fabrication, relines and adjustment, etc. Published data indicate that 55% of seniors in CLCs felt that dental treatment in the residences was important to their dental health. This was higher (56% and 67%) in the older age groups.

After assessing these factors, the Committee recommends that the responsibility for organizing and managing a dental service to residents of CLCs be placed at the local level. This would result in a delivery system more consistent with the unique needs of seniors in a variety of CLCs and available local resources.

a. <u>Public Health Units Option</u>

Public health units, through their dental directors, would be mandated to develop, offer and manage a service delivery system capable of providing dental care to residents of CLCs and those bed-bound in private homes. The service would be a logical extension of health promotion activities for seniors and become a follow-up to these preventive efforts. The service could employ providers on a fee-for-service, salaried, or capitation basis or a combination. For example, the screening and preventive services could be rendered by salaried staff and treatment providers reimbursed by any one of the previous options. The health unit would be responsible for the purchase, maintenance and provision of proper portable or fixed equipment, materials and supplies.

The Committee understands that the Underserviced Area Program of the Ministry of Health is negotiating with health units to assume the management of the dental coaches serving remote areas of Ontario north of and including the Muskoka/Parry Sound Districts. The health units have stated that these coaches need to provide more than the children's services offered in the past and include treatment to seniors both independently living and those in CLCs in the communities visited by the coach.

If an institution provides a treatment or preventive program for their residents, the health unit would be responsible to ensure that the services meet the standards of mouth care recommended earlier in this report.

b. Collective Living Centres Option

All CLCs would be required to appoint a dental director with authority over institutional staff concerning matters of dental health. The director would develop and manage a dental program to meet the needs of residents in that particular CLC. The CLC would reimburse the director on a regular basis for overall management responsibilities, perhaps in the manner presently used to reimburse medical directors in some CLCs. The CLCs could reimburse the director for specific services rendered to residents on a fee-for-service basis, on a salaried or other payment option. The dental director could also contract out the treatment services to other providers. Standards of care would be developed and supervised by CLC inspectors acting on behalf of their respective provincial governmental branch.

E. Cost Estimates

In the course of its deliberations, the Committee has had access to only very limited amounts of utilization and cost data on existing dental care plans. For example, such information has been obtained for the Alberta plan and the discontinued British Columbia plan, although the latter is clearly out-of-date. However, it is important to note that the Committee has not had access to utilization or cost data for the 10-15% of the elderly population estimated to be covered by private insurance plans.

Despite these data limitations, the Committee has developed cost estimates for dental care for seniors in need. In developing these estimates, the Committee mainly relied upon published and unpublished surveys (see Appendix "D"). Since there are a number of studies and service programs for institutionalized seniors, the Committee believes that the utilization and cost estimates for this population are reasonably sound. However, given the relative lack of studies of the dental health status and service utilization patterns of seniors living independently in the community, the Committee believes that the estimates for this group are much less reliable, and should be treated with caution.

Estimates were developed separately for the institutionalized elderly and elderly persons living independently in the community. In turn, these two groups were divided into three groups, based on income, in order to compare the estimated cost for each of three possible low-income groups to the estimated cost for the elderly population as a whole.

This strategy reflects the Committee's belief that one approach the Government might take in introducing dental care for seniors is to provide coverage to low-income seniors, first, and expand to other groups as funds become available.

The data are presented for both the institutionalized elderly and those living independently in the community, in combined form, in the accompanying table. Readers who may be interested in the data sources, assumptions, and detailed calculations for the two groups separately, should refer to Appendix "F".*

Estimated Cost of Dental Care for Seniors in Need

1989 Cost

Income Group	Year One	Year Two	Year Three	Year Four	Year Five
(1) GAINS (A)	$ 14.6 M	$ 18.3 M	$ 22.2 M	$ 26.0 M	$ 29.9 M
(2) OAS/GIS incl. GAINS (A)	$ 37.6 M	$ 47.0 M	$ 56.8 M	$ 66.5 M	$ 76.2 M
(3) OAS/GIS + 15%	$ 53.5 M	$ 66.9 M	$ 80.7 M	$ 94.4 M	$108.1 M
(4) All Elderly	$182.2 M	$201.3 M	$220.9 M	$240.6 M	$260.2 M

Note: Costs for all groups include the cost of screening residents of "collective living centres" and rest and retirement homes.

See Appendix "F" for data sources, assumptions, and detailed calculations.

*Appendices available for use in the Ministry of Health Library, 15 Overlea Boulevard, Toronto, M4H 1A9.

VI PAYMENT OPTIONS FOR DENTAL TREATMENT

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VI. PAYMENT OPTIONS FOR DENTAL TREATMENT

A. Payment Mechanisms

The Committee reviewed the various options currently available in Ontario for payment for dental treatment and services. These include options for payment of providers.

Paying the Provider

1. Fee-for-Service
2. Salaried Providers (including full-time, hourly, sessional per-diem)
3. Capitation
4. Combination of Capitation/Fee-for-Service

1. Fee-for-service

Under fee-for-service, the provider is reimbursed for each item of service provided to the patient. In Ontario, for example, the dental association and denture therapy association provide their members with a suggested fee guide. For some social assistance programs, schedules of dental benefits and allowances are negotiated with government or other funding agencies.

It may be possible, however, to pay the practitioner a one-time flat fee for certain diagnostic and preventive services and for the once-yearly check-ups and cleanings and pay for all other services on a fee-for-service basis, according to a negotiated fee schedule and eligible service list.

Payment is made to the provider in one of two ways, either directly by the patient, who is reimbursed for covered services by an insuring agency (tiers garant) or directly by the funding agency (assignment or tiers payant.) Government programs generally reimburse the providers directly, eliminating the need for the patient to have "up front" funds for the initial payment. In addition, government programs do not allow extra billing by the provider.

2. Salaried Providers

Under this system, the provider is reimbursed on a full-time, hourly, sessional or per diem basis. Regulations under Part II of the Health Disciplines Act limit the salaried system to governmental agencies, educational institutions or to dentists employed by another dentist.

3. Capitation

Under 'pure' capitation, the dental care provider undertakes to deliver a specified range of services for a group of individuals or families who have chosen that office and agrees to accept a flat (usually monthly) per capita fee as total reimbursement, irrespective of the number or type of services provided.

4. Combination of Alternative Funding and Fee-for-Service

In Ontario at present, most capitation-type programs are termed 'managed dental care' by the plan administrators and are a hybridized form of capitation. These plans require that certain basic services be provided from the monthly payment with the more complicated and time-consuming services paid on a modified fee-for-service basis.

B. Discussion

The key issues in establishing a publicly-funded dental program for seniors are that the delivery system must be accessible and resources must be applied in the most efficient and cost-effective manner. It is clear to the Committee that the elderly population is not homogeneous and that the needs for dental services vary as a result of factors such as age, ethnic and cultural status, and place of residence. Therefore, the delivery system and remuneration approaches should be sufficiently flexible so that the provision of dental services in a given community can be readily adapted to the needs of the elderly in that community, taking into account specific social, economic, geographic, cultural and other local factors.

In reviewing the payment options currently available in Ontario, the Committee noted that each has its merits and that no one option would necessarily provide a better guarantee that the dental service needs of seniors would be met appropriately across the province. Accordingly, the Committee suggests that the Ministry of Health adopt a policy of supporting a range of payment options that might include fee-for-service, salaried positions, capitation, or combination schemes (e.g., capitation plus fee-for-service) to facilitate the development of appropriate service delivery arrangements.

APPENDIX "A"

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